Tempe Fire Department Policies and Procedures
EMS Documentation Standards
210.12
Rev ~~3-3-04~~ 9-28-06

PURPOSE

The Fire Department EMS incident report serves as the primary document regarding the type and extent of care delivered in the field. Information contained in the report is used for medical, legal, administrative, and evaluation purposes.

Documentation of information gathered through observations, assessments and questioning of the patient can be used for medical, legal, administrative, and evaluation purposes.

POLICY

EMS incident reports contain protected health information as defined by state and federal law. This information must be kept confidential and comply with Fire Department Policies 210.14 and 210.15. ~~TFD Policy on HIPAA~~) The pre-hospital encounter form, aka EMS incident report, provides legal documentation of the incident and patient care delivered by the EMS provider.

Documentation on EMS incident reports ~~must~~ should be as accurate and complete as the then existing circumstances reasonably permit. The following guidelines generally ~~standards~~ reflect state, regional, and local expectations of what should appear on a pre-hospital incident form. The policy of the Fire Department is to adhere to these ~~standards~~ guidelines when the then existing circumstances reasonably permit.

PROCEDURE

If the then existing circumstances reasonably permit, the EMT or Paramedic should normally document the following:

1. The EMS Incident Report Form provided by the Department ~~will be used~~.

2. All statistical data which should normally include all times, including dispatch, first unit on-scene, departure for hospital, and arrival to hospital. ~~will be completed. Include all times including dispatch, first unit on-scene, leave for hospital, and arrival to hospital (when possible).~~

3. The reason for triage and/or destination decision, i.e. patient request, physician order, closest appropriate. ~~Documentation of reason for triage and/or destination decision. i.e. patient request, physician order, closest appropriate.~~

4. Chief complaint ~~identified~~.

5. History of presenting illness or mechanism of injury ~~documented~~.

6. Past medical history, medication, and allergies.

7. Patient weight indicated if medications are given that are dose/weight dependent or the patient is a pediatric patient weighing less than 100 lbs.

8. Complete vital signs including blood pressure, pulse, respirations, skin temperature, capillary refill, pupils. (~~minimum of~~ two sets of vital signs are preferred when the then existing circumstances reasonably permit)

9. Treatments with procedure, time and by whom, and response to treatment. ~~documented with procedure, time and by whom, and response to treatment.~~

10. Telemetry communication documentation including time of patch, name of physician or intermediary, orders received.

11. Transfer of care documented, i.e. to Emergency Department (ED) staff, to another agency or crew on scene.

12. Patient condition at time of transfer of care.

13. ~~Complete~~ Primary and secondary assessment.

14. Presence of the following signatures: ~~Signatures present:~~

    a. Pre-hospital provider and certification level.

    b. RN or Physician accepting patient at ED or pre-hospital provider accepting care.

15. ~~Include~~ The following when documenting treatment and/or procedures:

    a. Oxygen - time, amount, delivery device, patient response.

    b. Oral airway - patient unresponsive, no gag reflex, size, patient response.

    c. BVM ventilation - oxygen amount, ventilation rate, adequate chest expansion bilaterally, patient response.

    d. Intubation - route, size of tube, placement verified by five point auscultation, adequate chest expansion bilaterally, centimeters noted at route site, patient response.

    e. Suction - route, description of fluid, amount, patient response.

    f. Needle thoracostomy - tracheal position before and after, site, size of needle, noted free air/fluid, breath sound auscultated before and after, patient response.

    g. CPR - time started, CPR in progress, CPR discontinued/time, pulses present with CPR, pulses absent before CPR, patient response.

    h. Defibrillation/cardioversion - EKG rhythm identified, watts used/time, successful/unsuccessful, if utilizing cardioversion, whether ~~consider~~ sedation used prior to procedure, pulses after procedure, patient response.

    i. EKG Strip - rhythm interpretation, strip attached with patients name, date, time and lead written on strip, document settings and patient response if utilizing external pacemaker. Attach strips will be attached to the original (white) and base station (yellow) copies of the EMS incident form.

j. Intravenous therapy - solution used, time, size of catheter, site, rate, amount infused upon transfer of patient, fluid challenge amount, patient response after fluid challenge.

k. Medication - drug name, amount, route, patient weight if administering weight related dosages. Time of administration.

l. Stabilization - time, pulses before and after spinal or extremity stabilization. if unable to stabilize, document that it was maintained manually.

16. If the patient or legal guardian refuses treatment or transportation, include documentation of the following when the then existing circumstances reasonably permit:

a. Present mental status.

b. Presence/absence of alcohol/drugs of the person refusing.

c. Patients (or guardian's) statement of refusal.

d. Advice given to patient to obtain care and consequences of not doing such.

e. Patient's/guardian's signature on refusal form.

f. If transported unwillingly, what's the reason for doing so.

g. Receipt of HIPAA Notice of Privacy Practices information.